

<b>Case Number:</b>	CM14-0157525		
<b>Date Assigned:</b>	10/29/2014	<b>Date of Injury:</b>	03/13/1997
<b>Decision Date:</b>	12/10/2014	<b>UR Denial Date:</b>	09/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/25/2014

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 57 year-old male with date of injury 03/13/1997. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 08/05/2014, lists subjective complaints as pain in the low back, right more than left. The patient is status post L4-5 laminectomy in 2000; status post failed spinal cord stimulator trial in 2001; status post lumbar fusion 2004; and status post left shoulder arthroscopy (date not provided). The patient reported none of the surgeries have been helpful. Objective findings: Examination of the lumbar spine revealed tenderness to palpation of the lumbar paraspinals, muscle spasm, and limited lower back movements. Sensation was decreased in dermatomal distribution at the lower extremities. The patient also had tenderness at the right more than the left knee, right shoulder, and cervical spine. Range of motion of the cervical spine was reduced and there was decreased sensation in dermatomal distribution of the upper extremities. Tinel's sign was positive at both wrists. There was no documentation supplied for review to conform that the patient had ever previously attended physical therapy, acupuncture, or aqua therapy treatments. Request for a urine drug screen was certified on 03/17/2014. The patient underwent an MRI of the cervical spine on 12/13/2013 which was notable for C5-6 narrowing of the ventral CSF space and flattening of the ventral cord as well as mild bilateral neuroforaminal narrowing. MRI of the lumbar spine on the same date was notable for mild multilevel lumbar spondylosis and mild left-sided neuroforaminal narrowing at the L5-S1 level. Findings suggestive of a large exophytic cyst arising from the lower pole of the right kidney, was also noted.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**Twelve (12) Aquatic Therapy sessions: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22.

**Decision rationale:** The MTUS states that aquatic therapy can be recommended as an optional form of exercise therapy, where available, as an alternative to land-based physical therapy; but as with therapeutic physical therapy for the low back, it is authorized as a trial of 6 visits over 2 weeks, with evidence of objective functional improvement, prior to authorizing more treatments with a total of up to 18 visits over 6-8 weeks. The request is for a more aquatic therapy sessions and has allowed for a trial. The request for twelve (12) Aquatic Therapy sessions is not medically necessary.

**Twelve (12) Acupuncture sessions: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204, Acupuncture Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** The Acupuncture Medical Treatment Guidelines state that the initial authorization for acupuncture is for 3-6 treatments. Authorization for more than 6 treatments would be predicated upon documentation of functional improvement. The request for 12 treatments is greater than the number recommended for a trial to determine efficacy. The request for twelve (12) Acupuncture sessions is not medically necessary.

**(1) Urinalysis: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43.

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines recommends using a urine drug screen to assess for the use or the presence of illegal drugs, a step to take before a therapeutic trial of opioids, to aid in the ongoing management of opioids, or to detect dependence and addiction. There is no documentation in the medical record that the urine drug screen was to be used for any of the above indications. Therefore, the request for urinalysis is not medically necessary.

**(1) Functional Capacity Evaluation: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty, Functional capacity evaluation (FCE)

**Decision rationale:** The Official Disability Guidelines state that a functional capacity evaluation is appropriate if, case management is hampered by complex issues and the timing is appropriate; such as if the patient is close to being at maximum medical improvement or additional clarification concerning the patient's functional capacity is needed. Functional capacity evaluations are not needed if the sole purpose is to determine a worker's effort or compliance, or the worker has returned to work. There is no documentation in the medical record to support a functional capacity evaluation based on the above criteria. Therefore, the request for Functional Capacity Evaluation is not medically necessary.

**Gastrointestinal Specialist Re-evaluation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, Independent Medical Examinations and Consultations, Page 127

**Decision rationale:** According to the ACOEM guidelines, a referral request should specify the concerns to be addressed in the independent or expert assessment, including the relevant medical and non-medical issues, diagnosis, causal relationship, prognosis, temporary or permanent impairment, workability, clinical management, and treatment options. The medical record lacks sufficient documentation and does not support a referral request. Therefore, the request for Gastrointestinal Specialist re-evaluation is not medically necessary.

**MRI of the Abdomen:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Guideline Clearinghouse

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Ultrasonography Practice Parameters and Technical Standards; Performance of an MRI Examination of the Abdomen and/or Retroperitoneum; Resolution 39, Amended 2014

**Decision rationale:** The MTUS and the Official Disability Guidelines are silent on this issue. Referencing the American College of Radiology Practice Parameters and Technical Standards,

among the numerous primary indications for abdominal MRI, the indication most closely associated with the patient's problem states that an ultrasound should be ordered for abnormal laboratory values or abnormal findings on other imaging examinations suggestive of abdominal and/or retroperitoneal pathology. There is no documentation that the above criteria. MRI of the abdomen is not medically necessary.

**CT of the Cervical Spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177, 178, 182.

**Decision rationale:** The MTUS states that an MRI or CT is recommended to validate diagnosis of nerve root compromise, based on clear history and physical examination findings, in preparation for invasive procedure. In addition, the ACOEM Guidelines state the following criteria for ordering imaging studies: 1. Emergence of a red flag, 2. Physiologic evidence of tissue insult or neurologic dysfunction, 3. Failure to progress in a strengthening program intended to avoid surgery, 4. Clarification of the anatomy prior to an invasive procedure. There is no documentation of any of the above criteria supporting a recommendation of a CT of the cervical spine. CT of the cervical spine is not medically necessary.

**MRI of Bilateral Wrists:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 85.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, & Hand (Acute & Chronic), MRI's (magnetic resonance imaging)

**Decision rationale:** The Official Disability Guidelines recommend an MRI of the wrist or indications following trauma, suspected fracture, tumor, and suspected Kienbock's disease. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. Documentation in the medical record does not support and MRI of the wrist based on the above criteria. MRI of bilateral wrists is not medically necessary.

**Abdominal/Renal Ultrasound studies:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Radiology; Diagnostic Radiology:

Ultrasonography Practice Parameters and Technical Standards; Performance of an Ultrasound Examination of the Abdomen and/or Retroperitoneum; Resolution 39, Amended 2014

**Decision rationale:** The MTUS and the Official Disability Guidelines are silent on this issue. Referencing the American College of Radiology Practice Parameters and Technical Standards, among the thirteen primary indications for abdominal ultrasound, the indication most closely associated with the patient's problem states that an ultrasound should be ordered for abnormal laboratory values or abnormal findings on other imaging examinations suggestive of abdominal and/or retroperitoneal pathology. The medical record fails to document any of the primary indications or abdominal ultrasound. Abdominal/renal Ultrasound studies are not medically necessary.

**MRI of the Cervical Spine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177, 178, 182.

**Decision rationale:** The MTUS states that an MRI or CT is recommended to validate diagnosis of nerve root compromise, based on clear history and physical examination findings, in preparation for invasive procedure. In addition, the ACOEM Guidelines state the following criteria for ordering imaging studies: 1. Emergence of a red flag, 2. Physiologic evidence of tissue insult or neurologic dysfunction, 3. Failure to progress in a strengthening program intended to avoid surgery, 4. Clarification of the anatomy prior to an invasive procedure. There is no documentation of any of the above criteria supporting a recommendation of a cervical MRI. MRI of the cervical spine is not medically necessary.